Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Apr 15, 2014;	2014_128138_0011 (A1)	O-000171-14 O-000202-14	Complaint

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

Long-Term Care Home/Foyer de soins de longue durée

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAULA MACDONALD (138) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for C00#1 was extended at the request of the licensee. The new compliance date for C00#1 is April 8, 2014.

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 15 day of April 2014 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

PAULA MACDONALD

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Apr 15, 2014;	2014_128138_0011 (A1)	O-000171-14 O-000202-14	Complaint

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

Long-Term Care Home/Foyer de soins de longue durée

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAULA MACDONALD (138) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 13, 17, and 19, 2014

O-001252-13, O-000171-14, and O-000202-14

During the course of the inspection, the inspector(s) spoke with the President and CEO, Coordinator of Clinical Practice and Performance, Vice President of Support

Services, Vice President of Building Services, Vice President (VP) of Resident Care, several personal support workers, a recreation aide, a registered nurse, several registered practical nurses (RPN), several food service worker, several residents, and a volunteer.

During the course of the inspection, the inspector(s) reviewed several resident health care records, observed two breakfast meal services, observed a portion of a medication pass, toured several resident home areas, monitored air temperatures and hot water temperatures throughout the home, toured the laundry room and several rooms that house the laundry chute, and toured several resident rooms.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Accommodation Services - Maintenance

Dining Observation

Minimizing of Restraining

Nutrition and Hydration

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 section 71. (3) (a) in that it failed to ensure that each resident is offered a minimum of three meals daily.

Long Term Care Homes (LTCH) Inspector #138 arrived in the dining room on a unit at 8:50am on March 17, 2014 and noted that there were several residents in the dining eating breakfast with the exception of Resident #9 who was seated at a dining room table without a meal. LTCH Inspector spoke with the food service worker, Staff #102, who stated that Resident #9 would not have breakfast until there was a personal support worker available to feed the resident. LTCH Inspector noted that there were no personal support workers in the dining room. The only people in the dining room, aside from residents, were a food service worker and a volunteer. There was an RPN who was in and out of the dining but was occupied with administering medications.

LTCH Inspector continued to monitor the breakfast service and observed that the RPN, Staff #103, transported Resident #9 from the dining room to the lounge at 9:58am. The resident had not been provided breakfast. The LTCH Inspector monitored the resident for the upcoming beverage pass to determine if additional food or fluid would be provided to the resident but it was observed by 11:30am that the resident was not offered or provided any other food or beverage and the resident was moved back into the dining room for lunch. The LTCH Inspector spoke with the unit RPN, Staff #103, and requested that staff provide Resident #9 his/her lunch first as the resident did not have breakfast.

LTCH Inspector observed a second breakfast meal service on the same unit on March 19, 2014 starting at 8:40am. Resident #9 was again observed sitting at a dining room table without a meal. The food service worker, Staff #101, stated that the resident had not yet eaten and again stated, as the food service worker two days prior, that a personal support worker would assist the resident with his/her meal when a personal support worker was available. The resident continued to sit at the dining room table until 9:59am when a personal support worker, Staff #108, was observed to move the

resident out of the dining room into the lounge. LTCH Inspector spoke with the RPN, Staff #104, and requested that Resident #9 be provided breakfast. LTCH Inspector observed Staff #108 return the resident to the dining room and provide the resident with a bowl of cream of wheat mixed with pureed bread and a glass of apple juice. The protein portion of the meal was not offered to the resident as it was no longer available.

LTCH Inspector reviewed Resident #9's health care record including the plan of care which indicated that the resident was at high nutritional risk due to several factors including being severely underweight. The weight record indicated that the resident's body mass index (BMI) was 18.2 which is considered underweight for the elderly population.

Additionally, at 10:05am on March 17, 2014 on the same unit, the LTCH Inspector observed that another resident, Resident #3, was assisted to the dining room. The resident was provided a cup of coffee at 10:15am by a volunteer but by 10:50 am, the resident had not been offered breakfast. LTCH Inspector asked Resident #3 about breakfast and the resident stated that s/he had not had breakfast but would like some. LTCH Inspector proceeded to find staff nearby to assist the resident with breakfast and upon return observed the resident being escorted off the unit for a hair appointment. Resident #3 returned to the unit at 11:50 am. LTCH Inspector spoke with the resident and s/he stated that he/she had not had anything to eat but that s/he was hungry. LTCH Inspector spoke with the unit RPN, Staff #103, and requested that Resident #3 be fed lunch first (along with Resident #9) as Resident #3 had not yet breakfast.

LTCH Inspector reviewed Resident #3's health care record which indicated that the resident was at high nutritional risk relating to a diagnosis of diabetes among other factors. [s. 71. (3) (a)]

2. The licensee failed to comply with O.Reg 79/10 section 71. (3) (b) in that it failed to ensure that each resident is offered a minimum of between-meal beverage in the morning and afternoon and a beverage in the evening after dinner

LTCH Inspector #138 was on the same unit the morning of March 17, 2014 and monitored resident care from 8:50 am through to the lunch meal at noon. The LTCH Inspector did not observe that beverages were provided to residents between the breakfast and lunch meal. LTCH Inspector spoke with a personal support worker, Staff #107, who stated that the morning between-meal beverage would be provided

with the lunch meal.

LTCH Inspector #138 was on the same unit again the morning of March 19, 2014. The LTCH Inspector was on the unit at 8:40am through to lunch and monitored residents for the delivery of between meal beverages. It was observed by the LTCH Inspector that residents were not offered or provided a between meal beverage in the morning. [s. 71. (3) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, section 8. (1) (b) in that the licensee failed to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

LTCH Inspector #138 arrived on the same unit on March 17, 2014 at 8:50am. The LTCH Inspector noted that there were several residents in the dining room eating breakfast. The food service worker, Staff #102, stated to the LTCH Inspector that the

breakfast meal service is scheduled to run from 8:00am until 9:30am each morning and further stated that after 9:30am the food service workers are required to leave the dining room and return to the main kitchen. Staff #102 further stated that left over breakfast menu items are to be returned to the kitchen for disposal. Staff #102 voiced frustration over the breakfast meal service as not all residents are in the dining room prior to the end of the scheduled meal service.

The LTCH Inspector observed the dining room the entire morning and noted that there was only one individual assisting residents, aside from the food service worker, with breakfast and this individual identified him/herself as a volunteer and further stated that it was his/her first day at the home. This volunteer was later joined by another volunteer at approximately 9:00am. No personal support workers were noted to be in the dining room during the course of the breakfast service (other than to transport residents to the dining room) despite several residents requiring assistance with their meal.

LTCH Inspector was able to verify the concern expressed by Staff #102 that not all residents were brought to the dining room prior to the end of the breakfast meal service that was scheduled to end at 9:30am. LTCH Inspector observed several residents brought to the dining room after 9:30am. For example, Resident #1, Resident #4, Resident #7, Resident #8, and Resident #10 were brought to the dining room between 9:35 and 10:10am. Resident #1, Resident #4, Resident #7, and Resident #8 were only offered a bowl of cereal and no toast or eggs that was part of the planned menu and available to residents prior to 9:30am. Resident #7 was later overheard by LTCH Inspector to complain to a personal support worker that s/he was still hungry but no additional breakfast was provided. Resident #10 was brought into the dining room at 9:56am and not offered a choice of cereal and was provided cold cereal. The resident was overheard expressing to the volunteer that s/he wanted hot cereal but was told that it was not available.

LTCH Inspector reviewed the plan of care for Resident #1, Resident #4, Resident #7, Resident #8, and Resident #10. The plan of care for these residents did not indicate that the residents were late risers in the morning.

LTCH Inspector observed another breakfast meal service on the same unit on March 19, 2014. Resident #9, who requires complete assistance with meals by staff was provided his/her breakfast at 10:15am as directed by the LTCH Inspector. The plan of care for this resident indicated that the resident is to have fortified foods as the resident is at high nutritional risk. Since the breakfast is over at 9:30 am, the fortified

breakfast food which was a fortified oatmeal had been returned to the kitchen and was not available for the resident. In addition, the pureed protein choice according to the menu was no longer available to Resident #9. Instead Resident #9 was provided cream of wheat and pureed bread along with apple juice.

LTCH Inspector spoke with a personal support worker, Staff #105, regarding work routines for the unit. Staff #105 stated that there were no work routines.

LTCH Inspector spoke with the VP of Resident Care regarding work routines for the personal support workers on Waterford unit. The VP of Resident Care stated that there were no work routines for the personal support workers as the philosophy of the home is to allow staff to be self directed in carrying out resident care. The VP of Resident Care did state that staff have demonstrated difficulties in carrying out self directed work. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is an organized program of personal support services on a specified unit to meet the assessed needs of the resident in the morning, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 section 73 (1) 9 and 10 in that the licensee did not ensure that the dining service provided residents with eating aides, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible nor did the licensee ensure that proper feeding techniques were used to assist residents with eating.

LTCH Inspector #138 arrived on the same unit on March 17, 2014 at 8:50am. The LTCH Inspector noted that there were several residents in the dining room eating breakfast and that there was one person assisting the residenst who identified him/herself as a volunteer on his/her first day at the home. Another volunteer arrived on the unit at approximately 9:00am to assist with the breakfast meal service. The two volunteers proceeded to provide intermittent assistance to some residents with meals but inappropriate feeding techniques were observed such as standing while feeding and handling food with their hands. Not all residents requiring assistance with eating were provided with adequate assistance. For example, Resident # 6, who's plan of care indicates that the resident requires supervision (needs oversight/encouragement/cueing) while eating was observed at 9:30am to try to eat his/her scrambled eggs by using his/her fingers. Assistance to finish his/her eggs was not provided to the resident until 10:10am when a volunteer stood and fed the resident the remaining eggs. Resident #4 was observed to be brought in the dining room at 9:45am and cereal was provided to the resident within five minutes but the resident was observed not eating. At 9:55am, a volunteer assisted the resident with two bites of cereal and then walked away from the resident. The resident did not eat any more cereal and at 10:10am the volunteer returned to assist the resident with a few more bites of cereal. The resident was left again with his/her cereal in front of him/her, not eating until 11:25am when a personal support worker assisted the resident with the remains of the cereal. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents on a specified unit are provided with personal assistance and encouragement during the breakfast meal, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 section 110. (2) 1. in that staff applied a physical device that has not been ordered or approved by a physician or registered nurse in the extended class.

LTCH Inspector #138 observed Resident #1 the mornings of March 17 and 19, 2014 and observed that the resident was in a wheelchair with a lap belt. LTCH Inspector spoke with a personal support worker, Staff #108, regarding the use of the lap belt for Resident #1. Staff #108 stated that the resident was not able to undo the lap belt and that the lap belt is a restraint for the resident. Staff #108 further stated that the resident had previously been walking and falling and, as a result, was placed in a loaner wheelchair from the home. This loaner wheelchair was pointed out by Staff #108 and it was noted by LTCH Inspector to have a lap belt. Staff #108 stated that

the lap belt on the loaner wheelchair was applied to the resident but that it did not fit Resident #1 well and that the resident was able to fall out of the wheelchair even with the lap belt applied. Staff #108 stated that Resident #1 recently received a new, fitted wheelchair with a lap belt that properly fits the resident.

Resident #1's health care record was reviewed and it was noted that the Kardex outlined the use of a trunk restraint for the resident but that the plan of care did not outline any use of restraints. The progress notes were reviewed and it was noted that the resident was admitted to the home in November 2013. Upon admission, the resident ambulated with a four wheeled walker. A progress note dated in March 2014 from physiotherapy indicated that the resident was in loaner wheelchair from the home and was being fitted for his/her own wheelchair with the family's knowledge. There were no progress notes that outlined the use of a restraint for the resident. Further review of the resident's health care record demonstrated that there was lack of documentation to demonstrate that the restraint was approved by the physician or a registered nurse in the extended class.

LTCH Inspector spoke with the unit RPN, Staff #104, regarding physician approval of the lap belt as a restraint for Resident #1. Staff #104 was unable to locate physician approval. [s. 110. (2) 1.]

2. The licensee failed to comply with O. Reg 79/10 section 110. (2) 4 in that the resident was not released from the physical device and repositioned at least once every two hours.

LTCH Inspector was on the same unit the mornings of March 17 and 19, 2014 and observed that Resident #1 and Resident #2 were both in a wheelchair with a lap belt that both residents were unable to open the lap belts. On March 19, 2014, LTCH Inspector monitored both residents from 8:40am until after the noon lunch meal. LTCH Inspector did not observe either resident to be released from the lap belt and repositioned during that time period which was more than three hours in duration. [s. 110. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff do not apply a physical device for restraining that has not been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, section 3. (1) 1. in that every resident was not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

LTCH Inspector #138 observed that Resident #3 was assisted to the dining room in his/her wheelchair for breakfast at 10:05 am on March 17, 2014. The resident was observed by LTCH Inspector to have both his/her upper thighs and backside exposed so that the resident's skin and incontinence product was visible. The resident was escorted to a hair appointment on the first floor at 10:50am and no attempts were made to cover the resident up. The resident returned to the unit at 11:50am and LTCH Inspector observed that the resident's thighs and backside were still exposed.

LTCH Inspector reviewed the resident's health care record and the plan of care indicated that the resident was a two person total assist for dressing. [s. 3. (1) 1.]

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 15 day of April 2014 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

PAULA MACDONALD

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L.O.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PAULA MACDONALD (138) - (A1)

Inspection No. / No de l'inspection : 2014_128138_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-000171-14 O-000202-14 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Apr 15, 2014;(A1)

Licensee / Titulaire de permis : ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

LTC Home / Foyer de SLD : ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LINDA CHAPLIN

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O.

To ST. PATRICK'S HOME OF OTTAWA INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all residents on Waterford unit are provided a breakfast meal daily.
This plan must be submitted in writing to Paula MacDonald, LTCH Inspector, at 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4 or by fax at 613-569-9670 on or before April 8, 2014.
While this plan is being prepared, the licensee must immediately ensure that all the residents on Waterford unit are offered a breakfast meal daily.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg 79/10 section 71. (3) (a) in that the licensee failed to ensure that each resident is offered a minimum of three meals daily.

Long Term Care Homes (LTCH) Inspector #138 arrived in the dining room on a unit at 8:50am on March 17, 2014 and noted that there were several residents in the dining room eating breakfast with the exception of Resident #9 who was seated at a

dining room table without a meal. LTCH Inspector spoke with the food service worker, Staff #102, who stated that Resident #9 would not have breakfast until there was a personal support worker available to feed the resident. LTCH Inspector noted that there were no personal support workers in the dining room. The only people in the dining room, aside from residents, were a food service worker and a volunteer. There was an RPN who was in and out of the dining but was occupied with administering medications.

LTCH Inspector continued to monitor the breakfast service and observed that the RPN, Staff #103, transported Resident #9 from the dining room to the lounge at 9:58am. The resident had not been provided breakfast. The LTCH Inspector monitored the resident for the upcoming beverage pass to determine if additional food or fluid would be provided to the resident but it was observed by 11:30am that the resident was not offered any other food or beverage and the resident was moved back into the dining room for lunch. The LTCH Inspector spoke with the unit RPN, Staff #103, and requested that staff provide Resident #9 his/her lunch first as the resident did not have breakfast.

LTCH Inspector observed a second breakfast meal service on the same unit on March 19, 2014 starting at 8:40am. Resident #9 was again observed sitting at a dining room table without a meal. The food service worker, Staff #101, stated that the resident had not yet eaten and again stated, as the food service worker stated two days prior, that a personal support worker must assist the resident with his/her meal when a personal support worker is available. The resident continued to sit at the dining room table until 9:59am when a personal support worker, Staff #108, was observed to move the resident out of the dining room into the lounge. LTCH Inspector spoke with the RPN, Staff #104, and requested that Resident #9 be provided breakfast. LTCH Inspector observed Staff #108 return the resident to the dining room and provide the resident with a bowl of cream of wheat mixed with pureed bread and a glass of apple juice. The protein portion of the meal was not offered to the resident as it was no longer available.

LTCH Inspector reviewed Resident #9's health care record including the plan of care which indicated that the resident was at high nutritional risk due to several factors including being severely underweight. The weight record indicated that the resident's body mass index (BMI) was 18.2 which is considered underweight for the elderly population.

Additionally, at 10:05am on March 17, 2014 on the same unit, the LTCH Inspector observed that another resident, Resident #3, was assisted to the dining room. The resident was provided a cup of coffee at 10:15am by a volunteer but by 10:50am the resident had not been offered a breakfast. LTCH Inspector asked Resident #3 about breakfast and the resident stated that s/he had not had breakfast but would like some . LTCH Inspector proceeded to find staff nearby to assist the resident with breakfast and upon return observed the resident being escorted off the unit to a hair appointment. Resident #3 returned to the unit at 11:50 am. LTCH Inspector spoke with the resident and s/he stated that s/he had not had anything to eat but that s/he was hungry. LTCH Inspector spoke with the unit RPN, Staff #103, and requested that Resident #3 be fed lunch first (along with Resident #9) as Resident #3 had not yet had breakfast.

LTCH Inspector reviewed Resident #3's health care record which indicated that the resident was at high nutritional risk relating to a diagnosis of diabetes among other factors.
(138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Apr 08, 2014(A1)

REVIEW/APPEAL INFORMATION

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L.O.

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L.O.

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15 day of April 2014 (A1)

Signature of Inspector / Signature de l'inspecteur : PAULA MACDONALD

Name of Inspector / Nom de l'inspecteur : PAULA MACDONALD

Service Area Office / Bureau régional de services : Ottawa